May 5, 2017

Cynthia Beane, MSW, LCSW
Acting Commissioner Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Re: Approval of Health Home State Plan Amendment WV SPA 16-0007

Dear Acting Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS), has completed its review of West Virginia State Plan Amendment (SPA) Transmittal Number 16-0007, Statewide Bipolar and at risk of Hepatitis B & C. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act (1945 of the Social Security Act). Individuals eligible to receive Health Home services include Medicaid members with bipolar disorder who are at risk for Hepatitis Type B and/or Type C (HH-BD/H). The Health Home model is person-centered, primary care-based, behavioral health integrated, and case-managed by an interdisciplinary team.

We approve West Virginia State Plan Amendment (SPA) Transmittal No. 16-0007 on May 4, 2017 with an effective date of April 1, 2017. Enclosed is a copy of the approved pages for incorporation into the West Virginia State plan.

In accordance with the statutory provisions at Section 1945 (c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, April 1, 2017 through March 31, 2019, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate March 31, 2019. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this Health Home State Plan Amendment, please contact Dan Belnap at (215) 861-4273 or Dan.Belnap@cms.hhs.gov.

Sincerely,

Francis T.
McCullough
Associate Regional Administrator

Enclosures

c: Ryan Sims, Bureau for Medical Services
Sabrina Tillman Boyd, CMS
Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Date: 05/04/2017
Head of Agency: Cynthia Beane
Title/Dept: Acting Commissioner, WV Medicaid
Address 1: 350 Capitol street, Room 251
Address 2:
City: Charleston
State: WV
Zip: 25301

MACPro Package ID: WV2017MH0001O
SPA ID: WV-16-0007

Subject
WV SPA 16-0007

Dear Cynthia Beane
This is an informal communication that will be followed with an official communication to the State's Medicaid Director.
The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for WV State Plan Amendment

<table>
<thead>
<tr>
<th>Reviewable Unit</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Health Homes Intro</td>
<td>4/1/2017</td>
</tr>
<tr>
<td>Health Homes Population and Enrollment Criteria</td>
<td>4/1/2017</td>
</tr>
<tr>
<td>Health Homes Geographic Limitations</td>
<td>4/1/2017</td>
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<tr>
<td>Health Homes Services</td>
<td>4/1/2017</td>
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<tr>
<td>Health Homes Providers</td>
<td>4/1/2017</td>
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<td>Health Homes Service Delivery Systems</td>
<td>4/1/2017</td>
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<tr>
<td>Health Homes Payment Methodologies</td>
<td>4/1/2017</td>
</tr>
<tr>
<td>Health Homes Monitoring, Quality Measurement and Evaluation</td>
<td>4/1/2017</td>
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</tbody>
</table>

For payments made to Health Homes providers under this new Health Homes Program submission package a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 4/1/2017 to 3/31/2019.

Sincerely,
Alissa DeBoy
(Name)
Deputy Director,
DEHPG

Effective Date: April 1, 2017
Superseded SPA: N/A
CMS Approval: May 4, 2017
Approval Documentation

<table>
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No items available

Package Information

- **Package ID**: WV2017MH0001O
- **Submission Type**: Official
- **Program Name**: Statewide Bipolar and at risk of Hep B & C
- **SPA ID**: WV-16-0007
- **Version Number**: 3
- **Submitted By**: Richard Ernest
- **Package Disposition**: Approved
- **Submission Date**: 2/8/2017
- **Approval Date**: 5/4/2017 11:46 AM EDT

Submission - Summary

MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

<table>
<thead>
<tr>
<th>Package Header</th>
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<td><strong>Initial Submission Date</strong></td>
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State Information

- **State/Territory Name**: West Virginia
- **Medicaid Agency Name**: WV Bureau for Medical Services

Submission Component

- State Plan Amendment
- Medicaid
- CHIP

Submission Type

- Official Submission Package
- Draft Submission Package

Key Contacts

<table>
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<tr>
<th>Name</th>
<th>Title</th>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becker, MD, James</td>
<td>Medical Director</td>
<td>(304)558-1700</td>
<td><a href="mailto:james.b.becker@wv.gov">james.b.becker@wv.gov</a></td>
</tr>
<tr>
<td>Ernest, Richard</td>
<td>Program Manager, Health Homes</td>
<td>(304)558-1700</td>
<td><a href="mailto:richard.d.ernest@wv.gov">richard.d.ernest@wv.gov</a></td>
</tr>
<tr>
<td>Young, Sarah</td>
<td>Acting Deputy Commissioner</td>
<td>(304)558-1700</td>
<td><a href="mailto:sarah.k.young@wv.gov">sarah.k.young@wv.gov</a></td>
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</table>
Executive Summary

West Virginia's State Plan Amendment (SPA) is health delivery model targeted for the treatment of Medicaid members with bipolar disorder who are at risk for Hepatitis Type B and/or Type C (HH-BD/H). The Health Home model is person-centered, primary care-based, behavioral health integrated, and case-managed by an interdisciplinary team.

Goals of this Health Home SPA include improving the health care experience, improving the health of populations, reducing per capita costs of health care, and promoting the integration of behavioral health into primary care.

Objectives include a reduction in emergency department use, hospital admissions and re-admissions, health care costs, reliance on long-term care facilities, and improving the health care experience, quality and outcomes for the individual and providers.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

Disaster-Related Submission

This submission is related to a disaster

☐ Yes
☐ No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

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<th>Amount</th>
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<td>Second 2018</td>
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Federal Statute / Regulation Citation

Affordable Care Act, Section 2703, Section 1945

Governor's Office Review

☐ No comment
☐ Comments received
☐ No response within 45 days
☐ Other
Authorized Submitter

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter

Richard Ernest

Title

None

Phone number

3045581700

Email address

richard.d.ernestjr@wv.gov

Authorized Submitter's Signature

Richard Ernest

I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

Submission - Public Comment

MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Package Header

Package ID

WV2017MH0001O

SPA ID

WV-16-0007

Submission Type

Official - Review 1

Approval Date

5/4/2017

Superseded SPA ID

N/A

Name of Health Homes Program

Statewide Bipolar and at risk of Hep B & C

Indicate whether public comment was solicited with respect to this submission.

Public notice was not required and comment was not solicited

Public notice was not required, but comment was solicited

Public notice was required and comment was solicited

Indicate how the public notice was issued and public comment was solicited

Newspaper Announcement

Name of Paper

Date of Publication

Locations covered

Charleston Daily Mail

11/29/2016

Central West Virginia

Charleston Gazette

11/29/2016

Central West Virginia

Dominion Post

11/29/2016

North Central West Virginia

Huntington Herald Dispatch

11/29/2016

Western West Virginia

News Register

11/29/2016

Northern West Virginia

Register Herald

11/29/2016

Souther West Virginia

Wheeling Intelligencer

11/29/2016

Northern West Virginia

Publication in state's administrative record, in accordance with the administrative procedures requirements

Date of Publication

Dec 2, 2016

Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification

Jan 27, 2017

Description of Letters and application will be sent to Behavioral Health

WV 16-0007

Superseded SPA: N/A

Effective Date: April 1, 2017

CMS Approval: May 4, 2017
mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used Providers listed in Care Connection; Providers listed in C3; Notification letter WVHA; WVSMA; Primary Care Physician/Family Health Practice: Home Health and Hospice Agencies; Advanced Nurse Practioners (WV Nursing Association); PT/OT; and Pharmacy Association.

### Select the type of website

- [✓] Website of the State Medicaid Agency or Responsible Agency

<table>
<thead>
<tr>
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<td>Website for State Regulations</td>
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### Public Hearing or Meeting

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<td>Other similar process for public input that afforded interested parties the opportunity to learn about the contents of the Demonstration application and to comment on its contents.</td>
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Other method

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<tr>
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<tr>
<td>Public Notices posted at County DHHR offices</td>
<td>11/22/2016</td>
<td>Attached public notice was posted in common area at all county DHHR offices</td>
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<td>Webinar</td>
<td>1/25/2017</td>
<td>Conducted a webinar to present information on the program, review provider application, review member letter, review SPA, provider standards, and other general design and overview.</td>
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Upload copies of public notices and other documents used

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<th>Name</th>
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<td>16-007 Health Home Bipolar-Hepatitis</td>
<td>2/8/2017 3:06 PM EST</td>
<td>PDF</td>
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<td>WVHealthHomesProviderLetterFinalapproved</td>
<td>2/8/2017 3:06 PM EST</td>
<td>PDF</td>
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Upload with this application a written summary of public comments received (optional)

No items available

Indicate the key issues raised during the public comment period (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility
- Benefits
- Service delivery
- Other issue

Submission - Tribal Input
MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Not Started | In Progress | Complete

Package Header

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<td>WV2017MH0001O</td>
<td>WV-16-0007</td>
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<td>Official - Review 1</td>
<td>2/8/2017</td>
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<th>Approval Date</th>
<th>Effective Date</th>
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<td>5/4/2017</td>
<td>N/A</td>
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</table>

Name of Health Program | Statewide Bipolar and at risk of Hep B & C Homes Program | Effective Date: April 1, 2017 | CMS Approval: May 4, 2017
One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

Yes
No

Submission - SAMHSA Consultation
MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

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Submission Type: Official - Review 1
Approval Date: 5/4/2017
Superseded SPA ID: N/A

Name of Health Homes Program: Statewide Bipolar and at risk of Hep B & C

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation: 12/8/2016

Health Homes Intro
MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Program Authority

1945 of the Social Security Act
The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program: Statewide Bipolar and at risk of Hep B & C

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

West Virginia's State Plan Amendment (SPA) is health delivery model targeted for the treatment of Medicaid members with bipolar disorder who are at risk for Hepatitis Type B and/or Type C (HIV-BD/H). The Health Home model is person-centered, primary care-based, behavioral health integrated, and case-managed by an interdisciplinary team. Regardless of the Health Homes Programs that a member may qualify for based on diagnosis, they will be allowed to be enrolled in one (1) Health Home at a time

Goals of this Health Home SPA include improving the health care experience, improving the health of populations, reducing per capita costs of health care, and promoting the integration of behavioral health into primary care.

Objectives include a reduction in emergency department use, hospital admissions and re-admissions, health care costs, reliance on long-term care facilities, and improving the health care experience, quality and outcomes for the individual and providers.
General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Population and Enrollment Criteria

MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups

Mandatory Medically Needy

- Medically Needy Pregnant Women
- Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults
- Medically Needy Children Age 18 through 20
- Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled
- Medically Needy Aged, Blind or Disabled
- Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

- Two or more chronic conditions
- One chronic condition and the risk of developing another

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)
Health Homes Geographic Limitations
MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Package Header

Package ID: WV2017MH0001O
Submission Type: Official - Review 1
Approval Date: 5/4/2017
Superseded SPA ID: N/A

SPA ID: WV-16-0007
Initial Submission Date: 2/8/2017
Effective Date: 4/1/2017

Not Started | In Progress | Complete

One serious and persistent mental health condition

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:
- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

Claims based information for automatic assignment based on prior relationship with Health Home provider or, in the absence of relationship, Health Home that is geographically closest to patient. Patient notification completed by mail and by health home for options including opting out.

☑️ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Not Started | In Progress | Complete

Healthy Homes Services
MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Package Header

WV 16-0007
Superseded SPA: N/A

Effective Date: April 1, 2017
CMS Approval: May 4, 2017
Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition
Comprehensive Care Management is the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each member. The care plan design will be developed with input from the interdisciplinary team of providers on the basis of information obtained from a comprehensive risk assessment that identifies the member’s needs in areas including: medical, mental health, substance abuse/ misuse, and social services. The comprehensive risk assessment will also include mental health and substance abuse screenings using standardized tools. HH Providers will be required to update the clinical/medical/social data received during an assessment at least every four months. The individualized care plan will include integrated services to meet the member’s behavioral health, rehabilitative, long term care, and social service needs, as indicated. The care plan will be developed with input from the interdisciplinary team of providers; identify the primary care physician, other health and behavioral health care providers, Care Manager, and other health team providers directly involved in the individual’s care; and also identify community networks and supports needed for comprehensive quality health care. The Care Manager is a member of the team and responsible for the maintenance of the care plan document and ensures the client receives a copy of the initial care plan and any time that changes are made. Goals and timeframes for improving the member’s health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update. Comprehensive care management will assure that the member or legal health representative is an active team member in the care plan’s development, implementation and assessment and is informed and in agreement with plan components. Member’s family and other recognized supports will be involved in the member’s care as requested by the member.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Penetration of HIT adoption in WV is variable at the current time, although a growing number of providers are adopting EHR’s in response to the federal incentive program and BMS has partnered with the WV Regional Extension Center to further promote the use of HIT within the Medicaid provider community. Providers will be expected to demonstrate a commitment to the use of HIT by all members of the Health Home team, as part of the application to serve as a Health Home. At minimum, a certified EHR is required at the primary care site; the EHR is expected to document the elements of an individual care plan for each Health Home member. The use of HIT is also encouraged in the identification of individuals who are at highest risk and in need of more intense care management services; this will be done through analysis of population level reports of member characteristics and utilization patterns. This may also be done through electronic responses to a health risk assessment tool.
To facilitate communication about care coordination and care management activities, various systems are being explored; however, none is expected to be in place prior to SPA implementation.
As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  - Description
  - Initial assessment and care plan development will be conducted in a face to face encounter. Follow-up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner

- Nurse Care Coordinators

- Nurses

- Medical Specialists

- Physicians
  - Description
  - Initial assessment and care plan development will be conducted in a face to face encounter. Follow-up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
Care Coordination

Definition
Care Coordination is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data. Care coordination manages resource linkages, referrals, coordination and follow-up to plan-identified resources. Activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes and communicating with other providers and members/family members.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/family members. Health Home providers will be encouraged to utilize their EHRs and/or patient portals to link to health information and resources applicable to the member's condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner
  
- Nurse Care Coordinators
  
- Nurses
  
- Medical Specialists
  
- Physicians
  
- Physician's Assistants
  
- Pharmacists
  
- Social Workers
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Doctors of Chiropractic
  
- Licensed Complementary and alternative Medicine Practitioners
  
- Dieticians
  
- Nutritionists
  
- Other (specify)
Health Promotion

Definition
Health Promotion includes the provision of: health education specific to a member’s health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include but are not limited to: substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members. Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member’s condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member’s condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Care Coordinators
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurses
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Medical Specialists
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Physicians
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Physician's Assistants
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Pharmacists
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Social Workers
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Doctors of Chiropractic
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Licensed Complementary and alternative Medicine Practitioners
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Dieticians
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nutritionists
  **Description**
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Other (specify)

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Effective Date: April 1, 2017
CMS Approval: May 4, 2017

WV 16-0007
Superseded SPA: N/A
Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition
Comprehensive Transitional Care is care coordination services designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each enrollee transferred from one caregiver or site of care to another, the health home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. The transition could include any inpatient care to home and community based services and supports. This is accomplished through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Health Home providers will be encouraged to develop partnerships that maximize the use of HIT across various caregivers and care settings. The provider will be encouraged to use HIT when available to communicate with health facilities and to facilitate interdisciplinary collaboration among all care team members. Providers will be encouraged to share information through the statewide HIE once that capability becomes available. Providers will also be encouraged to provide enrollees with web-based access to their records that can follow the enrollees as they transition to different care settings.

To facilitate post-hospital follow-up, BMS will be exploring a means of communication to health homes about enrollees who have been admitted to a hospital. QIO will provide via its web-based system a notification to the assigned Health Home when a non-MCO member has had a request for medical or psychiatric hospitalization made/authorized. The MCOs will be encouraged to provide like information to the Health Homes for their members served by a Health Home.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Individual and Family Support (which includes authorized representatives)

Definition
Individual and Family Support Services include service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members’ and support members’ knowledge about the member’s diseases, promote member’s engagement and self-management capabilities, while assisting the member to achieve their care plan.

A primary focus of individual and family supports will be strengthened through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member’s ability to self-manage their health and participate in the ongoing care planning.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Health Home providers will be encouraged to utilize their EHRs and/or patient portals to link to health information and resources applicable to the member’s condition. The use of a patient portal or PHR is encouraged to provide for patient/family interaction with the care team and for development and monitoring of
shared care plans. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner

- Nurse Care Coordinators

- Nurses
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Medical Specialists

- Physicians
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Physician's Assistants

- Pharmacists

- Social Workers

- Doctors of Chiropractic

- Licensed Complementary and alternative Medicine Practitioners

- Dieticians

- Nutritionists

- Other (specify)

Referral to Community and Social Support Services

Definition
Referral to Community and Social Support Services includes the identification of available community resources, active management of referrals, access to care, including long term services and supports, engagement with other community and social supports, coordination of services and follow-up. This may include but not limited to, Alcoholics Anonymous and/or Narcotics Anonymous.

The Community and Social Support Services network includes development of policies, procedures and accountabilities (through contractual agreements, where applicable) which clearly define the roles and responsibilities of the participants in order to support effective collaboration between the health home and community-based resources, and the member.

The member’s care plan will include community-based and other social support services that address and respond to the member’s needs and preferences, and contribute to achieving the care plan goals.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Health Home providers will be encouraged to utilize HIT as feasible to initiate, manage and follow up on community based and other social services referrals.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Nurse Practitioner

- Nurse Care Coordinators

- Nurses
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- Medical Specialists

- Physicians
  - Description: Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type | Description
--- | ---
Care Coordinator; Others | Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

The admission continuing stay criteria for Tier 1 will be: Medicaid Eligibility and documented diagnosis of a Bipolar Disorder that are determined to be at risk for becoming infected with or currently have Hepatitis B and/or C.

The criteria for Tier 2 will be: at least one of the core health home services has been provided during the previous quarter and documented in the member’s medical record. There has been marked deterioration in behavioral stability demonstrated via an appropriate screening tool and or marked deterioration of medical stability or a change in the complexity of the medical issues identified requiring daily co-ordination.

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Health Homes Providers

MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

Package Header

Package ID | WV2017MH0001O
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Submission Type | Official - Review 1
Approval Date | 5/4/2017
Superseded SPA ID | N/A

SPA ID | WV-16-0007
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Initial Submission Date | 2/8/2017
Effective Date | 4/1/2017

WV 16-0007
Superseded SPA: N/A

Effective Date: April 1, 2017
CMS Approval: May 4, 2017
Types of Health Homes Providers

- Designated Providers

  Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

  - Physicians

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed health care practitioner

  - Clinical Practices or Clinical Group Practices

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed health care practitioner or group

  - Rural Health Clinics

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed rural health clinic

  - Community Health Centers

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed community health center

  - Community Mental Health Centers

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed community mental health center

  - Home Health Agencies

  - Case Management Agencies

  - Community/Behavioral Health Agencies

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed community or behavioral health agency

  - Federally Qualified Health Centers (FQHC)

    Describe the Provider Qualifications and Standards
    WV Medicaid enrolled licensed federally qualified health centers

  - Other (Specify)

- Teams of Health Care Professionals

- Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

West Virginia’s provider infrastructure will include a designated primary care physician or advanced practice nurse practitioner, working with multidisciplinary teams in a variety of possible settings: primary care and solo medical practices; comprehensive community behavioral health centers with a primary care service base; providers who serve special populations; academic medical centers; other entities meeting established qualifications.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services

2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders

4. Coordinate and provide access to mental health and substance abuse services

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families

7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services

8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services

10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Description

The State will provide support to providers using a variety of media. Specific programs will be developed and determined based on feedback from providers and identification of needs. This will include face to face training on the requirements and expectations of the SPA, including outreach, assessment, documentation, invoicing, and reporting. Scenarios will be used to illustrate the expectations for care coordination and other health home services. A website has been set up to provide additional information about the SPA and will include access to recorded training webcasts as well as provider manual and FAQ's. Providers will have a specific Quality Improvement Organization (QIO) trainer consultant assigned to their agency in which they may request training or assistance. The Quality Improvement Organization (QIO) trainer consultant will be on the provider’s site at least one time every twelve months providing training based upon the findings of a record review and certification audit. The findings of these reviews will be analyzed to determine a training plan for all Health Home Providers.

The State will provide support to providers using a variety of media. This will include face to face training on health home requirements and expectations for all providers prior to the effective date of the SPA, including outreach, assessment, documentation, invoicing and reporting. A learning community of health home participants will be set up to allow for regular sharing of experiences among health homes providers and teams. Qualitative information about program implementation will be collected through this community. And Lessons learned will be shared through the health home learning community.

Other Health Homes Provider Standards

The state’s requirements and expectations for Health Homes providers are as follows

1. Health home providers must enroll or be enrolled in the WV Medicaid program and agree to comply with all Medicaid program requirements.

2. Care coordination and the other five health home services, as identified by CMS, will be provided to all health home enrollees by an interdisciplinary team of providers. As described in the Provider Infrastructure section above, each health home will define its multidisciplinary team in a manner that assures capacity to provide or arrange for the six defined health home services. However, at minimum, each team shall include a primary care provider (physician or advanced practice nurse), a licensed behavioral health specialist, a registered nurse, and a care manager (who could be the nurse or the behavioral health specialist for persons with SMI). Each team shall include an individual who is designated as a care coordinator but who may also fill other roles. The care manager leads the health home team and is accountable for ensuring that patient needs are identified and that an integrated care plan is developed and coordinated for each enrollee and is carried out by assuring access to medical and behavioral health care services and community social supports as defined in the care plan.

Additionally, the health home team includes physicians, pharmacists, pharmacists, social workers, mental health workers, health educators, community health workers, and others, dependent on the delivery model of the health home.

Specific qualifications for the required team member roles are as follows:

- Provider—MD, DO, or Advanced Practice Nurse licensed in the state of WV;
- Behavioral Health Specialist—Masters prepared individual licensed in the state of WV in counseling, psychology, or social work;
- Nurse—Registered Nurse licensed in the state of WV;
- Care Manager—Registered Nurse or licensed Behavioral Health Specialist. Completed an internal credentialing process through a provider designation as a health home;
- Care Coordinator—Licensed Registered Nurse or Bachelor’s Degree in a social science with some applicable patient care or counseling experience.

Completed an internal credentialing process through a provider designation as a health home.

The health home provider must identify the means for care plan documentation, communication, and integration across the various service delivery components of the health home. Health home providers can either directly provide or subcontract for the provision of health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor. The health home provider is required to describe the methods and processes for providing the health home services. Where contractual relationships are to be used, the health home provider must demonstrate that formal written agreements are in place at the time health home services are initiated.

3. Health home providers are expected to establish a medical neighborhood of local community providers that will serve as referral providers for various medical, behavioral health, and facility services, and as applicable to managed care, the medical neighborhood must include providers that are part of the contracted network of the managed care entity. At minimum, each health home must include provision of behavioral health services or must establish a formal partnership with a behavioral health entity in order to assure appropriate access to a range of behavioral health services for all of its health home enrollees. Behavioral health services will be available 24 hours a day/7 days a week. Hospitals that are part of a health home neighborhood must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a health home or other facility based settings to ensure coordination of all aspects of transitional care for current and eligible recipients. Documentation describing the medical neighborhood and hospitals’ referral commitment must be provided.

4. Health home providers must demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including the promotion of mental and emotional well-being and the prevention of substance abuse.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate access to comprehensive preventive care management, care coordination, and transitional care across settings.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

5. The health home provider must use an electronic health record system that qualifies under the Meaningful Use provisions of the HIT/HITEC Act, and which allows the patient’s health information and plan of care to be accessible to the interdisciplinary team of providers. Providers may also access the West Virginia Health Information Network (WVHiN), which is an interactive network.

6. As a condition of being a designated provider, the health home must agree not to refuse enrollment of eligible potential health home enrollees referred by Bureau for Medical Services (BMS).

7. As a condition of being a designated provider, the health home must be subject to audit and monitoring systems currently in place for Bureau for Medical Services programs. Documentation of health home measures for enrollees is subject to audit by a Bureau for Medical Services contractor. In addition, the provider understands that BMS will monitor outcome measures and the provider is subject to discontinuation of designation as a health home if measures are not reported as required, or if anticipated outcomes are not achieved.

8. Health Home provider qualifications will initially be assessed and approved by the DHHR Bureau for Medical Services. Once a provider gains Health Home provider status, the provider record in the State’s MMIS will include this designation. Subsequent Health Home provider recertification, conducted by QIO, will...
occur within thirteen months of the Health Home designation anniversaries. The QIO is under contract with the Bureau for Medical Services to provide utilization management for certain Medicaid-covered services, including prior approval for inpatient hospital admission.

### Health Homes Service Delivery Systems

**MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017**

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**Package Header**

- **Package ID**: WV2017MH0001O
- **SPA ID**: WV-16-0007
- **Submission Type**: Official - Review 1
- **Approval Date**: 5/4/2017
- **Superseded SPA ID**: N/A

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- ☑ Fee for Service
- ☐ PCCM
- ☐ Risk Based Managed Care
- ☐ Other Service Delivery System

### Health Homes Payment Methodologies

**MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017**

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**Payment Methodology**

The State's Health Homes payment methodology will contain the following features

- ☑ Fee for Service
- ☐ Individual Rates Per Service
- ☑ Per Member, Per Month Rates
- ☑ Fee for Service Rates based on
- ☐ Severity of each individual's chronic conditions
- ☐ Capabilities of the team of health care professionals, designated provider, or health team
- ☑ Other

**WV 16-0007**
**Superseded SPA: N/A**
**Effective Date: April 1, 2017**
**CMS Approval: May 4, 2017**
Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Reimbursement will only be made for health home services not covered by any other available Medicaid reimbursement options. The criteria required for receiving a monthly PMPM reimbursement is:

a) The member meets health home criteria and is so flagged in the MMIS;

b) The member is enrolled as a health home member with the health home provider billing for the service reimbursement;

c) At least one of the core health home services has been provided during the previous month and documented in the member's medical record;

By submitting the basic or intense health home service code for reimbursement, the provider is attesting to the fact that at least one of the six health home services has been provided during the month.

The following steps are used to determine the rates:

1. The state will use West Virginia wage specific data obtained from the Bureau for Labor Statistics (BLS) for each Health Home designated multidisciplinary team professional.
2. Salary will be adjusted for fringe benefits and assigned at a rate of 40 percent of the average BLS annualized salary for each wage classification.
3. The fringe adjusted annual salary is converted to an hourly rate per wage classification assuming 2,080 work hours.
4. The hourly rate for each wage classification is adjusted for each multidisciplinary team member's level of participation in the health home team for each payment by dividing the team members assigned level of participation by the total assigned monthly participation for the health home team.
5. The monthly health home team level of participation assigned to services is two hours PMPM and Health home participation levels will vary based on each targeted health home condition.
6. The PMPM rate will equal the sum of hourly rates for each health home multidisciplinary team member that has been adjusted for fringe benefits and participation level.

Payment for Health Home services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically noted otherwise in the plan, the state developed rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule. Rates will be published on the Bureau's website at: www.dhhr.wv.gov/bms. The agency's fee schedule rate was set as of July 1, 2014, the start date of WV 1st Health Home program, and is effective for services provided on or after that date. All rates are published on the agency's website.

Two Level System: Payment will be made on a per member per month (PMPM) basis for each health home enrollee. Basic and Intensive Health Home Services comprise the two-level system. Health Home Service Level I: The basic Level I health home service code is intended to cover the provision of all of the six health home services, as determined to be appropriate to meet the member needs. At the time of enrollment, the Health Homes requests prior authorization of the Level I service for each enrollee through a web-based prior authorization system managed by QIO. Both at initial enrollment and at the time of each service request, the QIO verifies the person's Medicaid eligibility. Payment will be made based on the presence of the Health Home attribute in the member's MMIS record, the member's Medicaid eligibility during the service month, a prior authorization in the MMIS including the service month and the submission for payment through the MMIS of the service code for Health Home Services: Level I. The benefit package for all Health Home enrollees includes eligibility for services covered by the basic health home code.
Health Home Service Level II: A second health home level of service, Level II, is available for those health home enrollees determined to require more intense service for a period. Health Homes request prior authorization of the Level II intensive service through the same web-based prior authorization system managed by QIO. At the time of a request for Level II service, QIO will conduct verification of the HH member's Medicaid eligibility. Each Medicaid member whom qualifies for Level II Health Home service will receive a one-month authorization. Authorization is based on clinical information presented by the Health Home provider, including hospitalizations, ER utilization, assessment scores, and clinical judgment documenting a deterioration of the enrollee's condition and crisis situation requiring stabilization. Payment will be made based on the presence of the Health Home attribute in the member's MMIS record, the member's Medicaid eligibility during the service month, a prior authorization in the MMIS including the service month and the submission for payment through the MMIS of the service code for Health Home Services: Level II.

Assurances

☑️ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved: There will be a contractual agreement with Health Home Providers and other providers, such as waiver services providers and targeted case management providers, regarding non-duplication of similar benefits. In addition, Bureau for Medical Services does periodic retrospective reviews for these services.

☑️ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑️ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑️ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Home Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - Statewide Bipolar and at risk of Hep B & C - WV - 2017

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Data Source: MMIS
Measurement Specifications: Compare total cost of care for health home members to costs of care for similar cohorts not enrolled with a HH. Calculations will exclude claims for high cost outliers more than three standard deviations from the mean annual cost and will include incremental HH reimbursement. HH member costs will also be compared pre- and post- HH implementation.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

West Virginia currently has several HIT initiatives in place and underway that will support the provision of health home services and improvement of care coordination across the care continuum.

- The state is in the process of implementing a statewide health information exchange that will facilitate the sharing of information across various care delivery settings. All health home providers will be expected to participate in the HIE as it is implemented across the state. The HIE will be used to capture meaningful use measures and several of these are incorporated into the information that will be used to monitor and evaluate health home services. Until the HIE is fully in place in the state, each health home provider will also be expected to use their EHR to generate a Continuity of Care Document (CCD) that can be shared with other providers in order to facilitate transitions in care and care coordination across care settings.

- A pharmacy data warehouse is in place that will provide for monitoring of patient adherence to prescribed drug regimens as well as appropriate use of pharmaceutical agents.

- A data warehouse/decision support system has been implemented to capture MMIS claims data as well clinical data that will flows through the HIE. This data warehouse will be the primary source of evaluation information for the health homes initiative.

- A web-based vendor system will be used for documentation of medically necessary services and authorization information.

- Information on hepatitis will be shared with the West Virginia Bureau for Public Health: the Office of Epidemiology and Prevention Services maintains a data base of information regarding incidence of hepatitis in the State.

Quality Measurement and Evaluation

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WV 16-0007
Superseded SPA: N/A
The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.

The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

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